Medicaid and CHIP Eligibility Review Pilot Guidance

Pilot: 4th Round

Issued: November 2015

Background

The State Health Official (SHO) Letter 13-005 issued on August 15, 2013 directs states to implement Medicaid and Children's Health Insurance Program (CHIP) Eligibility Review Pilots in place of the Payment Error Rate Measurement (PERM) and Medicaid Eligibility Quality Control (MEQC) eligibility reviews for fiscal years (FY) 2014 – 2016. States will conduct four streamlined pilot measurements over the three year period. The pilot measurement results should be reported to CMS by the last day of June 2014, December 2014, June 2015, and June 2016. Additionally, SHO Letter 15-004, issued on October 7, 2015, extended the pilot measurement through FY 2017, requiring states to conduct a fifth pilot study with results due to CMS in June 2017. This guidance is intended for the fourth round of pilots. Guidance for subsequent pilots will be released at a later date.

The Medicaid and CHIP Eligibility Review Pilots consist of two independent components, the case review component and the test case component. States are required to:

1. Case Review Component: Pull a sample of actual eligibility determinations made by the state and perform an end to end review from initial application/point of transfer to the final eligibility determination (also referred to as 'case review').
2. Test Case Component: Run test cases (provided by CMS) through the UAT section of the state's eligibility determination system.

Guidance for running and reporting on the test cases will be issued separately and will remain on a separate track and timeline. Guidance for Round 4 pilot proposals for the case review of state eligibility determinations follows below.

Round 4 Overview

With the completion of three rounds of pilots, states should be preparing to resume the PERM eligibility reviews. The goal moving forward with each round of the eligibility pilots is to reduce or eliminate eligibility errors that have the potential to be identified in the PERM review process prior to the resumption of PERM eligibility and the calculation of state eligibility error rates. Through these pilots, states should focus on establishing an audit trail, maintaining records, and including a review of all determinations that may be subject to review in future PERM eligibility reviews. To effectively prepare states for PERM, some determinations that may have may have been excluded in prior pilot rounds should now be included in reviews for Round 4.

CMS made some significant changes to the guidance from previous rounds and as such, states should not continue the processes used in the Round 3 pilots. Specific differences in Round 4 requirements include:

- **Sample timeframe:** States will be required to review determinations (initial and redeterminations) made between April 2015 through March 2016.
- **Sample size:** Because Round 4 covers determinations made in a full year, states will now be required to sample at least 250 cases rather than 200 as required in prior pilots (which only covered six month periods). Specifically, this includes an increase in the

minimum number of active Medicaid MAGI cases from 65 to 115 cases. States should also review at least 85 CHIP active determinations, 20 non-MAGI Medicaid active determinations, and a total of 30 Medicaid and CHIP negative determinations

- **Exclusions:** Changes to the list of exclusions. Additional cases should now be included in the review.
- **Error definition:** Changes to the definition of error to include Eligibility Error- EE and Group Error – GE.
- **Finding code descriptions:** Changed term to "Qualifier" and revised descriptions based on review and state feedback on previous round.
- **Eligibility Category:** Requirement to report the category/group/tier of each case reviewed. States should be prepared to provide this information.
- **Payment reviews:** Changes in the payment review requirements that will result in a more consistent review methodology.

All changes are discussed below in more detail.

Eligibility Support Contractor (ESC) Pilots

States participating in Round 3 of the ESC pilots will not need to submit a Round 4 pilot proposal as the ESC pilots will serve as the Round 4 case review pilots. However, ESC pilot states are still required to:

- Run and report on test cases for Round 3 (Guidance to follow separately); and
- Provide updates to FY 2014-2016 Round 3 case review corrective actions.

Due Dates

Pilot proposals for Round 4 are due to CMS no later than January 15, 2016. States will use the PERM Eligibility Tracking Tool (PETT) website to submit Round 4 pilot proposals using the same process used in Round 3. In general this process entails:

- Inputting pilot proposals into the PETT template. Word versions of the pilot proposal can be used for draft versions but CMS will not accept pilot proposals via email and a PETT upload function will not be available.
- Once pilot proposals are submitted, CMS will review and provide comments and/or approval within two weeks.
- If CMS does not approve the proposal, states will have one week to revise the proposal based on CMS comments.

Per the August 15, 2013 SHO letter, pilot findings are due to CMS no later than June 30, 2016. Detailed reporting guidance will be issued at a later date.

Overall Requirements

To evaluate the accuracy of the eligibility determinations, states will pull a random sample of cases for review. States should follow the sampling and review requirements provided below.

In the pilot proposals, states should provide information about CMS-approved mitigation plans or strategies, delayed renewal waivers in place, or any other information that impacts the eligibility review process or pilot approach. **CMS understands that all states may not be able to comply with all of the requirements below. In those cases, states should clearly identify those requirements and provide an explanation of the states' limitations in meeting them.**

Sampling Frame

States must construct sampling frames (i.e., universes) from which to draw cases for review that meet the below requirements. The sampling frames should include Medicaid and CHIP determinations (including MAGI, non-MAGI, active, negative, redeterminations, and initial determinations) made by the state April 2015 through March 2016.

Sampling Unit

The sampling unit is an **individual determination**.

The exact definition of determination types could vary by state for purposes of this pilot. In general, CMS considers the following as reasonable guidelines for defining each determination type:

- Active vs. Negative Determinations
    - Active determination – Determination that approved a new applicant enrollment in Medicaid or CHIP or continued a beneficiary's Medicaid or CHIP enrollment.
    - Negative determination - Determination that denied a new applicant enrollment in Medicaid or CHIP or terminated a beneficiary from Medicaid or CHIP.
- Initial Determinations vs. Redeterminations
    - Initial determination – Evaluation of eligibility based on an initial application. This includes determinations made for applicants that left the program and later reapplied.
    - Redetermination – Evaluation of continued eligibility for a beneficiary or termination eligibility for a beneficiary. These include annual redeterminations and redeterminations made outside the annual renewal process that are a result of a change in circumstances that require redetermination of eligibility.
- MAGI vs. Non-MAGI Determinations
    - MAGI determination – Determination of eligibility based on modified adjusted gross income (MAGI) and other ACA-related assessment and verification rules apply when determining eligibility.

- Non-MAGI determination – Determination for all other eligibility categories for which MAGI is not the standard for determining eligibility. These are the aged, blind, and disabled eligibility groups.

States should provide additional information about determination types that may be helpful for CMS in understanding the state's pilot.

Sampling Frame Construction

The following determination types must be included in state sampling frames for Medicaid and CHIP:

- Initial determinations
- Redeterminations
- MAGI determinations
- Non-MAGI determinations
- Active Determinations
- Negative Determinations

Reminder!
FFM D states should include determinations where state resolved inconsistencies and made final eligibility determination

States must include initial determinations and redeterminations from all types of applications, points of application, and channels applicable to the state. States should include all cases from Title XIX and Title XXI funding sources except for the required exclusions as listed on page 6 in the *Inclusions and Exclusions* section.

States have flexibility to determine how many sampling frames to build as long as all required determinations types listed above are included, and the state reviews the minimum number of non-MAGI Medicaid active determinations, MAGI Medicaid active determinations, CHIP active determinations, and Medicaid and CHIP negative determinations as described in the sampling section below. The state can determine what sampling frame and sampling strategy is used to meet these minimum requirements.

The Round 4 proposal must include the following regarding the sample frame:

- Specify how each determination type will be identified (e.g., specific codes; not identified until sampled, etc.)
- Confirm each determination type listed above will be included
- List the data sources used, who will pull the data and how data will be pulled (e.g., SQL query).

Timeframe

States must sample from eligibility determinations made between April 2015 and March 2016. States are not required to sample cases for each month of the review period and may choose to sample from smaller timeframes

Reminder!
States must sample determinations made within the review timeframe

within this twelve month review period.

The parameter states should use when developing the sampling frame is the determination date (i.e., decision date) and not the eligibility effective dates. States should be sampling determinations/redeterminations made within a specific timeframe, not individuals eligible during a specific timeframe.

States should indicate, in the pilot proposal, the timeframe of determinations (including initial determinations and redeterminations) from which the state is sampling and when the state plans to begin the sample selection process.

ALERT! Change from Round 3

Round 4 review timeframe = April 2015- March 2016. Review period covers one year.

Inclusions and Exclusions

In Round 4, CMS is requiring inclusion of certain types of cases that were previously excluded in Rounds 1 to 3. The rationale for minimizing exclusions in Round 4 is to better prepare states for the eventual re-start of PERM and the types of cases that will be part of that review. Generally speaking, states should include all cases that receive Title XIX or Title XXI funding or that were denied or terminated for Title XIX or Title XXI coverage.

Cases previously excluded but required to be **included** in Round 4 are:

- Cases under active beneficiary fraud investigation;
- Cases enrolled using targeted enrollment strategies;
- Cases in a presumptive eligibility period (before state has made a full eligibility; determination); and
- Title IV-E cases funded with Title XIX.

In a change from previous rounds, states will be including a review of cases where states did not make a full eligibility determination such as hospital presumptive eligibility or determinations made with targeted enrollment strategies. All types of presumptive eligibility cases, including those that are presumptively determined by the state, as well as those presumptively determined by a qualified entity or hospital, should be included in the review, if applicable in your state.

Additional information regarding the expected review of these newly included cases is described in the review section below.

ALERT! Change from Round 3- Exclusions

Reviews should include all cases from Title XIX and Title XXI funding sources with the exception of the required exclusions that have been revised in Round 4.

The Round 4 required **exclusions** are:

- Cases not matched with Title XIX or Title XXI federal funds including state-only cases;
- Express lane eligibility cases;
- Determinations made (and finalized) by the FFM;
- SSI cases in states with an SSA agreement under section 1634 of the Social Security Act; and
- State-funded Title IV-E (Foster Care and subsidized adoption).

States will be required to confirm that all cases will be included in the pilot review except for cases designated as exclusions.

Quality Control Procedures

States are expected to perform quality control checks on the sampling frame to ensure completeness and accuracy. States should include a description of sampling frame quality control procedures in their pilot proposal. Some examples of quality control checks include (but are not limited to):

- Select a preliminary test sample to ensure excluded cases have been removed from the universe and that new inclusions are present; and
- Compare the total count of pilot determinations in the sampling frame (and total count of pilot determinations in each stratum, if applicable) against existing benchmarks to assess reasonableness and completeness prior to sampling; and
- Review sampling frame totals in each month of the sampling timeframe to identify inconsistencies from month to month.

Sampling

Sample Size

States must sample a minimum of 250 total determinations for review. This is a change from Round 3. Additionally, states must sample a minimum number of the following types of determinations for review:

Determination Type	Minimum # Reviewed
Medicaid Active	**135**
Non-MAGI	20
MAGI	115
CHIP Active	**85**
Negative *(includes both Medicaid and CHIP)*	**30**
Total	**250**

States must review at least 135 Medicaid active determinations (determinations include both initial and redeterminations). At least 20 of those Medicaid active determinations must be non-MAGI and at least 115 must be MAGI. States must review at least 85 CHIP active determinations (including both initial and redeterminations) and at least 30 negative determinations (Medicaid and CHIP combined). **The 30 negative determinations cover CHIP denials and terminations, and Medicaid MAGI and non- MAGI denials and terminations.**

States can choose to and are encouraged to sample more than the minimum amount of determinations. States will be required to confirm that they will review the minimum number of each determination type. Proposals should include an explanation of the state's approach for meeting the minimum requirements for each determination type. If a state is unable to meet any of the above sampling size requirements, the state is required to provide a detailed explanation in the pilot proposal.

Alert! Change from Round 3

In Round 4, states must sample a minimum of 250 cases for review. Specifically, states are required to add 50 Medicaid MAGI Active cases in Round 4

Sampling Methodology

States must utilize a random sampling methodology. Oversampling is not required but states choosing to sample the minimum number of determinations may need to oversample to meet the minimum sample size requirements for each determination type if a case is dropped after the sample is pulled.

Reviews

Case Review Overview

The purpose of the case review is to evaluate the accuracy of the eligibility determinations, identify errors and deficiencies in the eligibility determination process, and conduct corrective actions based on the issues identified. The case review process should assess whether caseworkers and all automated and manual processes followed federal policies, state procedures (i.e., state verification plan), and other state policies while making the eligibility determinations. Case reviews should identify errors and deficiencies related to case worker and automated system processes that are utilized for making the eligibility determinations.

Eligibility determinations should be reviewed in accordance with the state's CMS-approved State Plan, state regulations, state eligibility manuals, agency policy and procedural manuals, verification plans, approved waivers, other state documents or directives that reflect current policy and procedure, and Federal guidance (e.g., federal laws and regulations, State Health Official and Medicaid Director Letters).

In a change from previous rounds, cases that are now included may have not had the eligibility determinations made by the Medicaid or CHIP agency, including the following types of cases.

- Presumptive eligibility (PE)-For determinations made by a hospital or other qualified entity, the presumptive eligibility determination should be reviewed by the state to attest the hospital or other qualified entity followed the appropriate process. Further, if the case is still within the presumptive eligibility period, the state should review that the entity making the presumptive eligibility determination followed the appropriate process. But, if the state has made a full eligibility determination on the case, the state should review the full determination.
    - If the hospital or other qualified entity followed the appropriate process in making the presumptive eligibility determination, but at the time the state made the full eligibility determination, the person was no longer eligible, the state should not report the case as an eligibility error or a deficiency.
    - If the hospital or qualified entity did not follow the appropriate process in making the presumptive eligibility determination, the case should be reported as a deficiency, regardless of the state's full eligibility determination.
- Targeted enrollment- For cases enrolled through targeted enrollment strategies, states should review and attest that the state followed the appropriate process and procedures for enrollment in Medicaid or CHIP.
    - If the review finds that the state did not follow the appropriate targeted enrollment strategy process for enrolling the individual in Medicaid or CHIP, the case would be reported as a deficiency.

Alert! Change from Round 3

Reviews should include Presumptive Eligibility and Targeted Enrollment cases in Round 4

To assist the pilot case review staff in conducting thorough reviews, a variety of other key staff should participate, including:

- **Eligibility Policy staff** who are familiar with how the state interprets both federal and state policy and are aware of what policy was in place when the determinations under review were made;

- **Eligibility/Caseworker staff** who are familiar with the caseworker processes and workflow, as well as how information is maintained (e.g., accessing case records); and

- **Systems staff** who are familiar with how the system processes cases and interacts with other systems (e.g., third party data sources).

While the pilot case review staff should be independent of the staff responsible for making eligibility determinations, the expertise of this staff will be critical in assisting the state pilot review staff in reviewing determinations in accordance with state processes and policies.

Preliminary Review/Information Collection

The pilot case review staff should first collect necessary background information on each case sampled for review. The review should:

1) Identify whether the case is active or negative.

2) Identify whether the case is Medicaid (Title XIX funds) or CHIP (Title XXI funds) (or would have been Medicaid or CHIP). For negative cases, if unable to specify whether Medicaid or CHIP, states should assign all negative cases to one program and specify how negatives are identified in pilot proposal.

3) Identify whether it is a MAGI or non-MAGI case (or what the case would have been if eligibility had been granted or extended).

4) Identify if the case is an initial determination or redetermination.

5) Identify the point of application (e.g., state agency/delegated entity, transferred from FFM, renewals).

6) Identify the type of application (e.g., single streamlined application, multi-benefit application)

7) Identify the channel (e.g., in-person, telephone, online, mail, transferred from Marketplace)

8) For active cases, identify the category/group that the case was placed in. States should be prepared to report this information. The spreadsheet will include options in a dropdown box and free text box for state specific information.

Assignment of Case ID

After collecting the necessary background information on the sampled case, the reviewer should use the information to assign a Case ID. States are required to assign a unique Case ID number to all cases reviewed. Although states may have created their own state-specific Case ID numbers,

states will be required to assign Case ID numbers using the format specified below for reporting. States will be required to report results on all cases reviewed in Round 3; not only the cases identified with error findings as in the previous rounds. Case ID's should be assigned using the following logic:

The Case ID number should be 9 digits and assigned using the following logic:

1	2	3	4	5	6	7	8	9
State Abbreviation		Budgeting Methodology	Program	Active vs. Negative Determination	Initial vs. Redetermination	Sequence Number		
Standard postal 2 character state abbreviation		M=MAGI N= Non-MAGI	M = Medicaid C = CHIP	A = Active N = Negative	I = Initial Determination R = Redetermination	3 digit sequence number assigned by the state to ensure each case has a unique case ID		

*Example: **ALMMAI003** decodes to:*

State: AL = Alabama

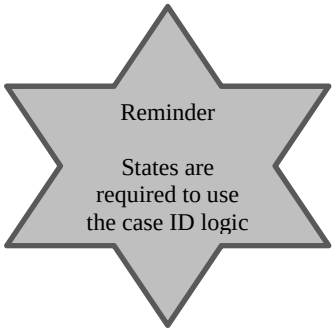
Budgeting Methodology: M= MAGI

Program: M = Medicaid

Active vs. Negative: A = Active

Initial vs. Redetermination: I = Initial

Sequence number = 003



Case Review Requirements

After collecting the necessary background information on the sampled case, the pilot review staff should begin conducting eligibility reviews considering state and federal policy to identify the accuracy of the eligibility determinations as well as internal and external processes that, while not resulting in eligibility determination errors, may result in deficiencies and therefore need to be addressed through corrective actions.

The eligibility case review should focus on whether the caseworker made the correct decision based on information available to the caseworker at the time of the decision. This pilot should also review whether the caseworker took appropriate actions to guide the case through the system and the system appropriately processed case information. Further, the review should include an evaluation of whether the case decision was made appropriately by system edits and whether the appropriate information was verified through the applicable data sources.

REMINDER!

States should have an audit trail in place so the reviewer can verify that appropriate processes were followed.

To address these considerations, the reviewer should take the following actions:

1) Review each case for all required eligibility criteria to confirm that the state made the appropriate determination of eligibility given information available on the application, through trusted third party data sources, and via hard copy documentation, as applicable. States should review criteria against state and federal policies.

    a. For system actions where calculations (e.g., income, household composition) were conducted as part of the determination, independently review the information used by the system and determine that calculations were done correctly. The reviewer should manually calculate income and household composition to evaluate whether the calculation performed by a caseworker or system was correct.

    b. For systems actions where third party data was used to verify self-attested information that was included on application, review system actions/interactions to determine if the appropriate data sources were utilized according to the state's verification plan and other state and federal policies.

2) Determine whether the eligibility determination for program coverage (Medicaid or CHIP) was correct or incorrect.

    a. If active and correct, determine whether the individual was placed into the correct eligibility category.

    b. If negative and correct, determine whether the individual was appropriately transferred to the SBM or FFM.

3) For systems actions where information was received from an outside entity, review systems actions to determine if the information entered the system appropriately and timely.

4) When processing was transferred between the system and a caseworker, review whether that transfer happened timely and appropriately. State should report findings if transfer between caseworker and system should have occurred but did not.

5) Determine whether the eligibility determination was made within the allowable timeframes.

There are situations where the information in the case file and/or system does not provide enough information to complete the active or negative case review. States should first attempt to gather the necessary information using other electronic sources. If the attempt to obtain the information is not successful, it may be appropriate to contact the client, as a last resort, to obtain the needed information.

Below are some examples of situations where additional information is needed:

- Applications or redetermination forms submitted to the state agency were not present in the case file. Therefore, what the client self-attested at the time of application or redetermination is not available for the pilot review.
- The electronic data matching did not meet compatibility thresholds (income) or did not pass criteria standards (citizenship/immigration status) and documentation was not in the case file to verify the element. Similarly, the household self-attested income and the electronic data source did not meet the reasonable compatibility standard, and the worker did not take any action to resolve the discrepancy.
- Information was identified as received (such as in case comments) but the documentation was not present in the case files.
- For non-MAGI cases, information was requested to verify assets (e.g., funeral accounts, investments) and income (e.g., pensions) that were either identified in the application or where sources such as SOLQ inquiries where it indicates payment is made to an asset account but no documentation, per state and federal policy, is present in the case file.

If the state is unsuccessful in obtaining requested information, the state should report the case as undetermined. States should report this issue using qualifier *#20 - "Documentation missing from record or no evidence in system that state conducted verification and state was UNSUCCSESSFUL in obtaining missing information."* States will also be required to report an additional qualifier that identifies the specific root cause of the undetermined findings (i.e., specify what information was missing and why the documentation was not present in the case file) and provide appropriate corrective action.

If the information is not missing, but unavailable to the reviewer (e.g. the information was accessed through a third party data source, but the state does not have an audit trail in place to confirm the match occurred), the state should report this finding and develop a corrective action plan to implement an audit trail to prevent these cases from being reported as undetermined when PERM resumes. States should report this as a deficiency using qualifier *# 21 - "Documentation missing in records or no evidence in system that state conducted verification system but state successfully obtained document/information to complete review.* States should also report an additional qualifier that identifies the root cause of the missing information (i.e., specify what information was missing and why the documentation was not originally available for the review) and provide corrective action.

For both of the situations above, the additional qualifier could be #15-*"State did not follow the process to verify the element in accordance with verification plan and other state and federal policies and this issue is not identified by other qualifier."*

Alert! Change from Round 3

States are required to report if information is unavailable to reviewer to complete reviews, even when the missing documentation is obtained through other sources. New qualifiers have been added to Round 4 to report this information.

Reviews should include all elements necessary to evaluate correctness of overall program eligibility as well as eligibility category. The state's case review should be a comprehensive review that includes all of the elements described below and any additional elements that the state uses to determine the appropriate program eligibility and eligibility group and a review of the eligibility determination process. At a minimum, the eligibility criteria in Table A below should be considered when reviewing cases for the accuracy of eligibility determinations. States should also include information for any additional review elements that are not included in the chart below but are included in the eligibility determination process.

For each of the eligibility criteria listed, states are required to conduct reviews to evaluate the accuracy of the eligibility determinations and identify errors and deficiencies in the processes, in accordance with state's CMS-approved State Plan, state regulations, state eligibility manuals, agency policy and procedural manuals, verification plans, approved waivers, other state documents or directives that reflect current policy and procedure , and Federal guidance (e.g., federal laws and regulations, State Health Official and Medicaid Director Letters.

States should consider the following when conducting reviews:

- What information from the case record will be reviewed?
- What information from eligibility screen will be reviewed to verify appropriate eligibility determination process was followed?
- How will compliance with verification plan be reviewed?
- Any other review process for eligibility criteria not listed.

Please note that all elements may have different implications for Medicaid vs. CHIP or MAGI vs. non-MAGI cases. Similarly, not all required review elements apply to both active and negative cases or to both initial determinations and redeterminations.

Table A: Review of Eligibility Criteria (Elements)

Eligibility Criteria (elements)	Considerations
Income	Was the client's income information correctly entered into the system?
	Was the state's reasonable compatibility standard, as specified in the verification plan, followed?
	Were income calculations correctly made based on MAGI vs. non-MAGI status?
	Was the eligibility determination made appropriately based on income?
	Was the individual placed in the appropriate eligibility group based on income?
Residency	Was residency verified in accordance with state policies, including the state verification plan?
Age (Date of Birth)	Was age verified in accordance with state policies, including the state verification plan?
	Was the individual placed in the appropriate eligibility group based on age?
	Was the individual placed in managed care or managed care plan based on age?
Gender	Was the individual placed in the appropriate eligibility group based on gender?
Social Security Number/Identity	Were state and federal policies followed in verifying the applicant's identity?
Citizenship and Immigration Status	Was citizenship/immigration status verified in accordance with state and federal policies?
	If applicable, did the state appropriately apply the reasonable opportunity period policy?
	Was the individual placed in the appropriate eligibility group based on citizenship and

Eligibility Criteria (elements)	Considerations
	immigration status?
Household Composition	Was the household composition constructed properly?
	Were all appropriate individuals included and excluded in the household?
Pregnancy Status	Was the individual placed in the appropriate eligibility group based on pregnancy status?
Caretaker Relative	Was the individual placed in the appropriate eligibility group based on caretaker relative status?
Medicare	Was Medicare status determined appropriately?
	Was the individual placed in the appropriate eligibility group based on Medicare status?
Application for Other Benefits	Was individual eligible to apply for other benefits?
Other Coverage	If the state has a waiting period, was the requirement met?
Assets	Were appropriate assets included/excluded from the state's calculation?
	Was the eligibility determination made appropriately based on asset criteria?
	Were assets calculated properly?
Transfer of resources and expenses	Did the state ask for appropriate documentation related to resource transfers?
	Was the individual eligible based on resource transfer criteria?
Medical eligibility requirements	Did the state ask for appropriate medical eligibility documentation?
	Was the individual eligible based on medical eligibility requirements?

Eligibility Criteria (elements)	Considerations
Expenses and Deductions	Did the state ask for appropriate documentation for expenses and deductions?
	Was the eligibility determination made appropriately based on expenses and deductions eligibility criteria?
Long-Term Care Specific Information (e.g., look back period assessment, spousal share, Miller Trust, etc.)	Did the state ask for appropriate documentation?
	Was the eligibility determination made appropriately based on long-term care criteria?

In addition to reviewing individual elements as described above, states are also required to review the overall case for correct processing as described in Table B below (at a minimum). The chart below provides a list of review criteria related to the overall process in making eligibility determinations.

For each of the processes listed below, the following information should be considered when conducting reviews:

- What information from the case record will be reviewed?
- What information from eligibility screen will be reviewed to verify appropriate eligibility determination process was followed?
- How will compliance with Verification Plan be reviewed?
- Any other review processes for eligibility criteria not listed in Table B below:

Table B: Review of Eligibility Process

Process Findings	Considerations
Notices Active and Negative Cases	Were appropriate notices sent for both active and negative cases that included all required and accurate information?
	Were notices sent in a timely manner?
Denial and Terminations Transfers	States utilizing FFM: Were denied cases transferred to the FFM appropriately?
	States utilizing SBM: • For SBM states that do not have shared eligibility system, was denied case sent to SBM for enrollment in a qualified health plan and determination of Advance Premium Tax Credit?

Process Findings	Considerations
	• For SBM states with shared eligibility system, was there confirmation that an APTC determination was made?
Transfers from FFM	If the application was transferred from the FFM, was information reused appropriately in accordance with verification plan?
Caseworker/system Transfers	If both system edits and caseworker actions were part of the eligibility determination process, did the caseworker transfer processing back to the system appropriately?
	For system actions where information was received manually from an outside entity, was the information entered into the system appropriately and timely?
Applicant information Requests	If information was requested from the applicant, was such information properly requested based on attestations and verifications, or existing data, and utilized properly in the eligibility determination?
Timeliness	Was case processed within the required state and federal timeframe?

Finding Code Overview

States will be required to use CMS specified finding codes to designate the results of the review and assign the appropriate qualifier for each case reported as an error or deficiency or undetermined as defined in this guidance. In Round 4, CMS made some changes to the terminology used to report results so states should be sure to review this information thoroughly. Based on a review of the state reporting from previous the round, CMS has updated the finding codes (previously called error codes) and qualifiers (previously called finding codes).

The **finding code** will specify if the sampled case had an incorrect overall eligibility determination, was incorrectly placed in a category/group, had a deficiency but the overall eligibility determination was correct, or was a correct case with no issues identified.

The **qualifier** will specify all issues that were found when reviewing the case (e.g. caseworker contacted applicant before exhausting other resources/efforts, household composition incorrect) which may or may not have led to an eligibility error. Only one finding code can be assigned to a case but a case can have multiple qualifiers. Correct cases should have no qualifiers reported. Errors, deficiencies, and undetermined cases should have at least one qualifier reported.

Reminder!

Only one finding code can be assigned to a case but a case can have multiple finding qualifiers.

In round 4, for cases identified as an Error, states are required to identify the qualifier that is associated with the primary cause of the eligibility determination

error. States should also report any additional issues identified during the review as deficiencies. States will only report one finding code for the error, but can report up to four qualifiers on the case.

Alert! Change from Round 3

States will be required to identify the qualifier that is associated with the primary cause of the eligibility error.

Finding Codes

Note: **Program** refers to Medicaid and CHIP.

In Round 4, there are changes to codes for reporting results. States should assign each reviewed case one of the finding codes specified below:

Table C: Review of Finding Codes

Code	Name	Definition	Notes
C	**Correct**	The overall eligibility determination was correct and no issues or problems were identified during the review of the case (i.e. everything was perfect).	No qualifier should be identified on these cases.

Code	Name	Definition	Notes
D	**Deficiency**	The overall eligibility determination and group/category assignment was correct but an issue was identified during the review of the cases that did not impact overall eligibility or the group/category enrollment.	At least one qualifier should be identified on these cases. Includes cases: • Overall eligibility determination and group/category assignment correct but issues were identified. • The information is unavailable to reviewer to complete reviews, even when the missing documentation or information is obtained through other sources. Requires two qualifiers
GE	**Group Error**	The decision about overall Medicaid or CHIP program eligibility was correct, but the case was assigned to the incorrect group/category.	Includes cases: • Enrolled in correct program (CHIP), but in the wrong category/group within CHIP • Enrolled in the correct program (Medicaid), but in the wrong category/group within Medicaid • This should **not** be used for cases that are determined eligible for Medicaid but should have been eligible for CHIP or vice versa • This should **not** be used for cases where decision about overall program eligibility was incorrect The primary cause of the error should be listed first. At least one qualifier should be identified on these cases.

Code	Name	Definition	Notes
EE	**Eligibility Error**	The decision about overall program eligibility was incorrect.	Includes cases: • Determined eligible for Medicaid but should have been eligible for CHIP or not eligible at all • Determined eligible for CHIP but should have been eligible for Medicaid or not eligible at all • Determined not eligible for Medicaid but should have been eligible for Medicaid • Determined not eligible for CHIP but should have been eligible for CHIP One qualifier must be identified on these cases. The primary cause of error should be listed first.
U	**Undetermined**	Insufficient information available for review to determine if the overall eligibility decision was correct or incorrect.	A case should be cited as "undetermined" only if the agency cannot verify eligibility or ineligibility using the case record documentation or other sources available at the time of review. A missing case record does not automatically make a case "undetermined." Two qualifiers should be identified on these cases.

Alert! Change from Round 3

Cases identified as enrolled in correct Medicaid or CHIP program but assigned the wrong group/category will be reported as an **error- Group Error-GE** and not a deficiency as in previous rounds.

Qualifiers

For every case for which an error, deficiency, or undetermined was cited, states should assign qualifiers that are applicable to the case. The primary cause of the issue should be listed as the first qualifier. Up to three additional qualifiers can be reported.

The qualifiers have been revised from the previous round. States should assign qualifiers using the revised list below:

Table D: List of Qualifiers

Code	Qualifiers
01	Case not appropriately transferred to the FFM/SBM. Negatives only.
02	Notice not sent upon denial or termination. Negatives only.
03	Notice sent but was not timely or did not contain correct information. Negatives only.
04	Notice of eligibility not sent. Actives only.
05	Notice of eligibility sent but not timely or did not contain correct information. Actives only.
06	Incorrect household composition established
07	Incorrect income level calculated
08	Assets not calculated correctly (non-MAGI only)
09	Income requirements not appropriately applied
10	Spend down policy not applied correctly (non-MAGI only)
11	Case did not meet medical eligibility requirements (non- MAGI only)
12	Third party data source not utilized as specified in verification plan
13	Applicant contacted before state exhausted all other efforts to verify information
14	Self –attested information was not used appropriately by the state.
15	State did not follow the process to verify element in accordance with verification plan and other state/federal policies and issue not identified by other qualifier
16	Case not processed within required state and federal timeframes including redeterminations
17	No action taken when reasonable compatibility standard not met
18	Citizenship/Immigration status not verified in accordance with state and federal policies
19	State did not appropriately apply reasonable opportunity period
20	Documentation missing in records or no evidence in system that state conducted verification and state was UNSUCCESSFUL in obtaining missing documentation/information. Undetermined only.
21	Documentation missing in records or no evidence in system that state conducted verification but state successfully obtained document/information to complete review. (Deficiency only)
22	Residency not verified in accordance with state/federal policies
23	Age not verified in accordance with state/federal policies
24	Identity not verified in accordance with state/federal policies
25	Medicare/other coverage status not appropriately determined/considered
26	State did not request for appropriate documentation related to resource transfers, expenses and deductions.(non-MAGI only)
27	State did not request for long-term care specific information appropriately. (non-MAGI only)
28	Case did not meet long-term care eligibility criteria. (non-MAGI only)
29	Case transferred from marketplace and information was not appropriately reused

30	System transfer did not occur appropriately including transfer of information to MMIS
31	Information not manually entered into system appropriately/timely
32	Case was denied/terminated without incorporating information that was provided before the submission timeframe
33	Case denied before allowing the appropriate timeframe for requests for information
34	State failed to follow-up on inconsistent or incomplete information
35	State failed to follow-up when there was a change of circumstance
99	Other

- States are only required to report one qualifier per issue identified and qualifier should describe the root cause of the issue. For example, if income was calculated incorrectly but all other processes were followed appropriately, the only qualifier that needs to be reported is *code 07- "income calculations incorrect"*.

- If there are multiple issues identified during review then other qualifiers should be reported. For example, if assets were not calculated correctly and case was not completed in a timely manner both qualifiers should be reported since these are separate issues.

- Qualifiers related to notices should only be used when the root cause of the problem identified is specifically a notice issue. For example, if the caseworker made an income calculation error and the notice contained incorrect information due to the incorrect income calculation, then the only qualifier to be reported is the incorrect calculation by caseworker. The notice issue is secondary.

- **If the caseworker /system processed the eligibility determination correctly and the notice was sent out with incorrect information due to a system notice problem, a notice qualifier would be used.**

Payment Reviews

States are required to conduct payment reviews to identify improper payments. At a minimum, this payment review must report payments made for all active case errors where the decision about overall program eligibility was incorrect. **This includes all cases identified as EE - Eligibility Errors.**

Timeframe

States will be required to collect payments for services received in the first month of eligibility and paid the first two months of eligibility or by April 30, 2016 (whichever comes first). States are required to report the total dollars incorrect.

States will be required to:

- Confirm that they will review payments as specified above. Identify all of the payments sources (e.g., MMIS, off-MMIS, Medicare premiums) that will be used to identify payments associated with these cases.

- Identify any issues, concern, or notes regarding your state's ability to conduct payment reviews in accordance to this Round 4 guidance.

Alert!! Change from Round 3

Payment review is required on all active cases reported as EE - eligibility errors. At a minimum, states are required to review claims for services received in the first month of eligibility and paid up through the following two (2) months or April 30, 2016, whichever comes first.

Quality Control

States are required to implement quality control measures to ensure accuracy of the reviews and to describe such measures in the pilot proposals. Examples of such measures would be performing a re-review on 10% of the sampled cases, on all errors, etc.

Reporting Results

Round 4 pilot results are due to CMS by June 30, 2016. CMS will issue a more detailed reporting and corrective action guidance including a reporting spreadsheet and template at a later date. States will submit individual case review finding as required in past PERM cycles and the Round 3 pilot and, will submit final findings and corrective actions to CMS. States will be required to confirm that the reported results are accurate and specify the state staff member designated to attest to the accuracy of the results.

Case-Specific Results

States are required to report results on all cases that were reviewed (not just the minimum number) through the Round 4 Pilot. States will be required to submit a findings spreadsheet (format to be released at a later date) that lists each case ID reviewed along with the results of the review of each case. States will be required to enter one finding code for each case and one primary and up to three additional qualifiers for each case. States will also report other case specific information (i.e. channel of application).

Results Narrative and Corrective Actions

States will also be required to submit a narrative with a discussion/analysis of the overall findings as well as a description of corrective actions. This narrative will be based on findings reported in Round 4 pilot. Corrective actions are required for each error and deficiency identified through the Round 4 pilot reviews.

Along with the Round 4 results and corrective actions, states are also required to provide an update on the Round 3 corrective actions, including an evaluation of the effectiveness of the corrective actions. This would include details on what corrective action is working and any updates to corrective actions that have been implemented for areas not working.

Recoveries

States are not required to refund the FFP for errors identified through these eligibility pilots. For errors identified through another audit or through other means outside of these pilots, states are subject to disallowances under the Medicaid recoveries regulation.

Staffing and Administrative Matching

States can utilize state staff (including existing MEQC/PERM review staff) or contractors to fulfill pilot requirements. If states use state staff for review, the state agency responsible for conducting the pilot reviews must be independent of the state agency that makes eligibility determinations (similar to the current PERM/MEQC independence requirements). The agency and personnel responsible for the development, direction, implementation, and evaluation of the eligibility reviews must be functionally and physically separate from the agency and personnel that are conducting the eligibility review pilots. The staff responsible for eligibility policy and making eligibility determinations must not report to the same direct supervisor as the staff conducting the eligibility pilots. States are required to describe how the agencies maintain independence in the pilot proposal.

Administrative matching should be claimed under PERM for Medicaid and CHIP according to the sample size from each program. States should claim as they normally would for the PERM program. As specified in the Affordable Care Act: State Resource FAQ at; http://www.medicaid.gov/state-resource-center/FAQ-medicaid-and-chip-affordable-care-act-implementation/downloads/Affordable-Care-Act-FAQ-enhanced-funding-for-medicaid.pdf, the enhanced funding for Medicaid eligibility systems operation and maintenance does not apply to PERM activities which are considered program integrity activities and eligible for the 50 percent FFP for Medicaid and 90 percent FFP for CHIP.

Questions

Please submit all questions to FY2014-2016EligibilityPilots@cms.hhs.gov.